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July 14, 2016

The Honorable Stephen C. Taylor, Commissioner
D.C. Department of Insurance, Securities and Banking
810 First Street NE
Suite 701
Washington, D.C. 20002

Re: Review of Group Hospitalization and Medical Services, Inc.'s 2011 Surplus

Dear Commissioner Taylor,

Thank you for the opportunity to comment on the community health reinvestment plan to be developed pursuant to the June 14, 2016, Decision and Order on Group Hospitalization and Medical Services, Inc.'s Plan. Please find our comments attached.

Sincerely,

Walter Smith, Executive Director
DC Appleseed Center

Richard B. Herzog
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cc: Mr. Philip Barlow, Associate Commissioner for Insurance
Mr. Adam Levi, Assistant General Counsel

D.C. Appleseed's Comments on the Commissioner's Plan for Holding GHMSI Accountable to the Requirements of the Medical Insurance Empowerment Amendment Act

July 14, 2016

DC APPLESEED'S COMMENTS ON THE COMMISSIONER'S PLAN FOR HOLDING GHMSI ACCOUNTABLE TO THE REQUIRMENTS OF THE MEDICAL INSURANCE EMPOWERMENT AMENDMENT ACT

DC Appleseed strongly supports the Commissioner's call for public comment on the plan the Commissioner will issue requiring Group Hospitalization and Medical Services, Inc. ("GHMSI") to dedicate $56 million of its excess surplus to community health reinvestment in a fair and equitable manner, pursuant to the Commissioner's June 14, 2016, Decision and Order and the Medical Insurance Empowerment Amendment Act ("MIEAA"). DC Appleseed also applauds the Commissioner's determination to issue the plan within 30 days from the close of the comment period.

DC Appleseed furthermore agrees with the Commissioner that because GHMSI failed to file a proposed plan to reinvest the $56 million as ordered by the Acting Commissioner, the Commissioner must not only develop and order implementation of a reinvestment plan, but he must also deny rate increases to GHMSI as prescribed by MIEAA.

In order to assist the Commissioner in developing the reinvestment plan and in determining how to implement MIEAA's requirement concerning denial of GHMSI rate increases, our comments address five issues: (1) guidance from MIEAA and its legislative history concerning the appropriate content of a fair and equitable reinvestment plan; (2) the importance of community input in developing the plan; (3) the potential engagement of local foundations in administering and monitoring the reinvestment plan; (4) the implications for the plan of the issues identified by the Commissioner in the June 14 Decision and Order; and (5) the appropriate implementation of MIEAA's requirement that GHMSI rate increases be denied for 12 months.

1. The Plan Adopted by the Commissioner Should Directly Address the City's Pressing and Unmet Healthcare Needs.

When the Council adopted MIEAA in 2008, it was prompted by the need to hold GHMSI accountable to its nonprofit, charitable and benevolent mission to serve the healthcare needs of the region. To that end, it provided that excess surplus was to be dedicated to the purposes encompassed in the definition of "community health reinvestment."

Under MIEAA, in order for the Commissioner to approve a plan, he must determine that the plan is "for dedication of the excess surplus to community health reinvestment in a fair and equitable manner." D.C. Code § 31-3506(g)(1). MIEAA broadly defines "community healthcare reinvestment" as "expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions." *Id.* § 31-3501(1A).

While "community healthcare reinvestment" is broadly defined under MIEAA, the legislative history indicates that the Council was particularly interested in: investment that promoted health coverage for low-income, uninsured, or underinsured individuals; operating subsidies for public health provider programs; and other community healthcare-related programs. D.C. Council,

Report on Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008," attachment E at 1–2. (Oct. 17, 2008). The Council noted a number of major health issues, including hypertension, obesity, and asthma, and disparities in health outcomes and access to high-quality healthcare. *Id.* at 8–9. It found that "[i]t is clear, that District residents are fighting an uphill battle in elevating the quality and expectancy of their lives." *Id.* at 9.

Nearly a decade later, the District continues to face many pressing healthcare needs. These needs are analyzed in recent reports by the D.C. Department of Health ("DOH") and the Urban Institute.[1] The DOH report recommends evidence-based strategies to improve a wide range of key health outcomes for D.C. residents, and the Urban Institute report identifies several acute needs concerning healthcare access, disparities in chronic disease, and adolescent mental health.

The Council recognized in passing MIEAA that GHMSI had an important role to play in addressing such needs, but it was not living up to its obligations. It "conclude[d] that CareFirst's history of straying from its public health mission, combined with unmet expectations and a lack of clear framework for accountability to its mission, call for a legislative response." Report on Bill 17-934 at 11. Accordingly, through MIEAA, the Council sought "to provide a framework to ensure that nonprofit hospital and medical services corporations pursue their public health mission." *D.C. Appleseed Ctr. for Law & Justice v. D.C. Dep't of Ins., Secs., & Banking*, 54 A.3d 1188, 1201 (D.C. 2012) (quoting Report on Bill 17-934 at 2).

Similarly, in passing MIEAA, the Council recognized the importance of GHMSI charging fair premiums to District residents and specifically noted the opportunity to provide community benefit to current and future subscribers, including in the form of premium reduction. In this instance, however, as explained in greater detail in our response to a question posed by the Commissioner concerning rebates, because current subscribers are not the essential source of GHMSI's excess surplus, and because measuring individual contributions that current subscribers may have made to that excess surplus is highly problematic, developing "fair and equitable" rebates to current subscribers presents extraordinary challenges. Moreover, implementation of the Patient Protection and Affordable Care Act has largely precluded effective opportunities for GHMSI to design premium rebates to District residents that would achieve community reinvestment by targeting premium reductions to current or future subscribers who might otherwise be uninsured or underinsured. Consequently, we focus in our comments on MIEAA's first remedy: the development of a fair and equitable community reinvestment plan to "promote and safeguard the public health."

2. The Commissioner Is Properly Receiving Community Views Concerning the Content of the Plan.

We applaud the Commissioner for inviting public comment on the development of a community reinvestment plan, and we expect a number of nonprofits and foundations that have spent years addressing healthcare needs of the city to offer their views on this issue. Not only do

[1] D.C. Dep't of Health, *DC Healthy People 2020 Framework* (April 2016); Lisa Dubay et al, Urban Inst., *Health Needs in the Washington Metropolitan Area: Potential Initiatives for Investment by CareFirst* (June 2016).

these organizations have the expertise to assess the fairest and most equitable use of the excess surplus, but their mission is to serve the public interest in the most effective way—which is also the purpose of MIEAA itself.

As explained below, we urge the Commissioner to identify guidelines for an appropriate community reinvestment plan and delegate the responsibility for implementing an appropriate plan to well-prepared community foundations that, as we understand their proposal, would form a common oversight board for this purpose. The Commissioner might predicate guidelines on recent reports—such as those just issued by the DOH and the Urban Institute—that provide an up-to-date assessment of the District's unmet health care needs. These reports themselves involved stakeholder and community participation. *See* D.C Dep't of Health at 1–2; Dubay at 3–4.

3. The Commissioner Should Designate Foundations to Administer the Plan.

By relying on MIEAA, public comments, and available public reports, DC Appleseed believes the Commissioner will be able to develop guideless for the fairest and most equitable use of the $56 million excess surplus. Once he does that, however, we do not think the best use of the Department of Insurance, Securities, and Banking's ("DISB") resources is for the Commissioner to determine the specific details of the plan or to administer the plan.

Nor do we think GHMSI should be asked or allowed to carry out that task. Instead, we think the Commissioner should accept a proposal that we understand will be made from local foundations with respect to administering the plan, including the choice of recipients, monitoring expenditures to ensure public accountability, assessing performance, and reporting to the DISB. As we understand their proposal, these functions would be governed by a board composed of representatives of the foundations, the community, the DISB, and GHMSI. The merit of the proposal lies not only in the fact that the foundations have the necessary experience and trust to do this job; but, also, because establishing a grant-making infrastructure would represent new and resource-intensive functions that are not within the traditional mission or experience of DISB but already exist in the foundations.

Certainly at this juncture, the tasks cannot with confidence be entrusted to GHMSI. The Council was already long "dissatisfied" with GHMSI's failure to meet its obligations when it adopted MIEAA nearly eight years ago. *D.C. Appleseed*, 54 A.3d at 1194. Yet since MIEAA's enactment and to this very day, GHMSI has continued to resist its obligations at every possible turn. Moreover, the excess surplus is money that never should have accrued to GHMSI in the first place. GHMSI has no special claim to govern the disposition of funds that it acquired through what its own president has described as "overcharges" to its subscribers.[2]

Moreover, GHMSI has overtly demonstrated that it would be a reluctant partner, consistently arguing that its surplus is too low or that it has already engaged in sufficient community

[2] *See* Hearing Tr. 103:24–25—104:1–6.

health reinvestment under MIEAA. Just three examples from the long history of these proceedings are sufficient to make this point:

- Following the first surplus review, the D.C. Court of Appeals roundly rejected GHMSI's construction of MIEAA and found that the Commissioner had failed to apply the law in upholding the company's 2008 surplus. *Id.* at 1219. In the subsequent, current surplus review, the Acting Commissioner determined that GHMSI's 2011 surplus was excessive by $268 million under MIEAA and rejected the analysis of the company's expert, Milliman, which GHMSI had used to argue that its surplus was actually not high enough. *In the Matter of Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.*, Decision and Order, Order No. 14-MIE-012 (D.C. Dep't of Ins., Secs., & Banking Dec. 30, 2014) [hereinafter Dec. 30, 2014, Decision].

- Rather than file a plan for dedicating the $56 million in excess surplus attributable to the District to the community health reinvestment, as ordered by the Acting Commissioner, GHMSI argued that it did not have excess surplus, and that it any case it had already engaged in sufficient community reinvestment. Plan of Group Hospitalization and Medical Services, Inc. filed with the Department of Insurance, Securities and Banking Pursuant to December 30, 2014 Order No. 14-MIE-012 (Mar. 16, 2015). Both of these contentions were patently wrong, for the reasons the Commissioner identified in the June 14 ruling.

- In the meantime, on June 1, GHMSI made a submission to the Commissioner stating that its surplus was not excessive under MIEAA, notwithstanding the Acting Commissioner's determination to the contrary. Letter from Chet Burrell, President & Chief Exec. Officer, CareFirst BlueCross BlueShield, to the Honorable Stephen Taylor, Comm'r, D.C. Dep't of Ins., Secs., & Banking (June 1, 2016). In fact, GHMSI has never even attempted to justify its surplus under the MIEAA standard in this annual filing, which is required by law to explain whether the company's surplus is excessive under the statute. D.C. Mun. Regs. tit. 26A, § 4601.1.

In this context, the Commissioner should entrust the responsibility for reinvesting GHMSI's excess surplus to prominent and respected foundations in the region that have the greatest expertise in making specific determinations about the most pressing healthcare needs, have expertise in grant-making programs to address them, and are familiar with the capacities and past performance of local organizations that are active in promoting and safeguarding local public health. The Commissioner, of course, should establish general guideline for eligible grantees. The Acting Commissioner's decision already provides guidelines on the types of expenditures that can qualify as "community health reinvestment." Dec. 30, 2014, Decision at 59–62. Since foundations have expertise in administering grant making programs, they are well-equipped to ensure the accountability and integrity of the plan. We would expect the foundations to propose suitable standards for accountability and monitoring, including the public availability of reports, for the Commissioner's consideration and approval.

We note that there is strong precedent for entrusting foundations to administer the reinvestment of GHMSI's excess surplus. For example, in the Fiscal Year 2014 Budget Support Act of 2013, the Council established a $15 million "Innovation Fund" (the "City Fund") to provide subgrants to nonprofit organizations. D.C. Code §§ 1-325.221–.226. The Act specified requirements for eligibility and accountability, and designated the Community Foundation for the National Capital Region as the "grant-managing entity" to administer the subgrant program according to the law's requirements.

There is also precedent for assigning administration to foundations in the context of nonprofit health plans. Under Maryland law, for example, if GHMSI were to convert to a for-profit entity, "the fair value of [its] public or charitable assets" would be distributed to the Maryland Health Care Trust, or both the Trust and a public or nonprofit charitable entity or trust that is independent of the company and dedicated to community healthcare. Md. Code Ann., State Gov't § 6.5-301(b)(3). And when Blue Cross of California converted from a nonprofit to a for-profit corporation, most of the proceeds went to healthcare philanthropy.[3]

For all these reasons, we urge the Commissioner to accept the foundations' proposal to ensure the effective and efficient implementation of the reinvestment plan.

4. The Issues Identified by the Commissioner Should not Affect the Development and Implementation of a $56 Million Reinvestment Plan.

Below, we provide comments on the specific issues that the Commissioner identified in his June 14 decision.

a. Length of time for dedication of excess surplus.

The excess surplus should be dedicated immediately, and not more than five years should be allowed for expenditure of all funds, consistent with prudent planning. First, as discussed above, we believe that GHMSI should immediately place the $56 million excess surplus in a trust, managed by an independent and experienced third party in the community interest. Second, we urge that the Commissioner require the trust manager to adopt a five-year timeframe for expenditure of all funds, in a manner consistent with independent assessments of critical community health needs such as those recently conducted by the DOH and the Urban Institute. Five years would reflect what we understand to be the judgment of the foundations concerning the absorptive capacity of local community healthcare organizations and the length of time necessary to ensure the most effective and efficient use of funds.

[3] *Conversion and Preservation of Charitable Assets of Blue Cross and Blue Shield Plans: How States Have Protected or Failed to Protect the Public Interest*, Community Catalyst 1 (Mar. 2004), http://www.communitycatalyst.org/doc-store/publications/conversion_and_preservation_of_charitable_assets_of_blue_cross_and_blue_shield_plans_mar04.pdf.

b. Whether the Patient Protection and Affordable Care Act should impact the timing of the dedication of the excess surplus.

The Patient Protection and Affordable Care Act should not impact the timing of the dedication of the excess surplus. Implemented in 2014, issuers in every state and the District of Columbia now have more than two years of experience in managing their business under the provisions of the Affordable Care Act. GHMSI has managed well under the Affordable Care Act, maintaining surplus at the company's desired level—but well above the level deemed efficient in the Acting Commissioner's decision. Some of the company's major concerns driving surplus—such as high premium growth—have, in retrospect, been significantly overstated.[6] In addition, GHMSI anticipates that the underwriting loss that it experienced on policies issued to individuals under age 65, diminishing in 2015, will turn to underwriting gains in 2016.[7] The company's own projections incorporating impacts of the Patient Protection and Affordable Care Act justify immediate expenditure of the company's 2011 excess surplus.

c. Whether the amount of excess surplus to be dedicated should be offset by any reduction in surplus between December 31, 2011 and December 31, 2015.

The amount of excess surplus to be dedicated should not be offset by any reduction in surplus that has occurred since 2011. From 2011 through 2015, GHMSI's surplus has ranged from 998% of risk-based capital (RBC) in 2011 to 882% in 2015, consistently well above the 2011 level of 721% that the Commissioner deemed efficient and consistent with financial soundness in his December 2014 decision.

Moreover, since 2011, GHMSI offered no statement in its rate filings of its intention to spend down excess surplus for community reinvestment; it offered this rationale only after the fact, when confronted with the Commissioner's finding of excess premium and at a time when all insurers set premiums in anticipation of heightened competition in the Exchanges.[8] The Commissioner's 2014 finding explicitly rejected premium reduction, when not measurably targeted

[6] GHMSI's reported annual premium growth rate was 7.7% in 2014 and 5.6% in 2015 inclusive of premium for GHMSI, plus its ownership share of CFBC and FEP premiums. In light of this experience, Milliman recommended reducing its premium growth assumptions of 7–11%, to 3–7% in future years. Phyllis A. Doran et al., Milliman, *Group Hospitalization & Medical Services, Inc.: Review and Consideration of Optimal Surplus Target Range* 8 (June 1, 2016).

[7] *Id.* at 7.

[8] *Statement of Group Hospitalization and Medical Services, Inc. in Support of Its March 16, 2015 Plan* 2 (Apr. 6, 2016), *available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/GHMSI%20Plan%20Reply.pdf.

to community benefit, as compliant with MEIAA.[9] We take up this issue again in our response in Part 4(g), below.

d. Whether the dedication of excess surplus should be suspended or modified in the event that adverse conditions reduce GHMSI's surplus.

There is no reason to anticipate adverse conditions that would warrant modifying or suspending excess surplus. As noted earlier, GHMSI's surplus levels as a percent of RBC have been remarkably stable since 2011, and in his June 1, 2016 letter to the Commissioner, Chet Burrell makes no note of extraordinary circumstances that would cause GHMSI to increase surplus beyond its current level and explicitly accepts Milliman's forecast that GHMSI has no need for additional surplus.[10] However, even if conditions would occur that are still more extraordinarily adverse than those already anticipated in GHMSI's current surplus, dedication of $56 million (the amount of GHMSI's excess surplus in 2011 attributable to the District) will not cause GHMSI to reduce its surplus to a level that even approaches the level that the Commissioner deemed efficient in 2011—and, as implied in GHMSI's own June 2016 report, the level that is relevant today. Even after GHMSI uses current surplus to finance the dedication of its excess 2011 surplus attributable to the District, its current surplus will remain at 830% of 2015 RBC, compared with 721% that the Acting Commissioner found to be efficient and consistent with financial soundness.

e. Whether the dedication of surplus could be modified pursuant to future reviews of GHMSI's surplus.

The dedication of surplus should not be modified pursuant to future reviews of GHMSI's surplus. To date, the process of requiring GHMSI to spend down excess 2011 surplus has spanned more than four years—including three years in which GHMSI has conducted its own surplus assessments and the Commissioner has reviewed the company's finances. During this time, GHMSI's financial circumstances have not changed materially, nor have its projections underlying target surplus. To

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[9] The commissioner sees no practical way to quantify past rate reductions or their benefit to subscribers, especially in cases where GHMSI asserts that a rate reduction consists of establishing a rate that is lower than the company's estimate of health care cost trend. In addition, the Commissioner sees no practical way to distinguish between a rate reduction made for competitive purposes versus one made to benefit subscribers. Reductions for competitive purposes arguably do not benefit subscribers to the extent that subscribers may obtain similar rates elsewhere in the market. Thus, although rate reductions may benefit subscribers, the Commissioner makes no attempt to quantify them and therefore does not endorse GHMSI's self-identified … premium rate reductions in the District market between 2010 and 2012.

Dec. 30, 2014, Decision at 61.

[10] "In December 2015, the Boards of GHMSI and CareFirst, Inc. . . . concluded that GHMSI's target surplus range continues to be appropriate…". Letter from Chet Burrell to the Hon. Stephen Taylor (June 1, 2016).

subject the Commissioner's 2014 finding of excess 2011 surplus attributable to the District to modification in future reviews would be effectively to suspend the implementation of MIEAA indefinitely and subvert the result that the Council intended in legislating MIEAA.

f. Whether rebates to current or past policyholders would be an appropriate expenditure for community health reinvestment.

We assume that the Commissioner is using "rebate" here in its ordinary sense, as a "*return* of part of the original payment for some service or merchandise."[11] We also assume that the "rebates" being contemplated would be designed to return to subscribers the amount of their particular contribution to GHMSI's excess surplus attributable to the District.

The plain language of MIEAA precludes such rebates to *past* policyholders: benefits to such policyholders are not within the definition of allowable expenditures for a community reinvestment plan. On the other hand, rebates to *current* policyholders are within the definition of allowable expenditures but, as addressed below, we believe it would be difficult if not impossible to calculate a fair and equitable plan including such rebates.

To constitute an appropriate component of a reinvestment plan, any proposed element in the plan—including rebates—must come within the statutory definition of "community health reinvestment," and must be "fair and equitable" within the meaning of the statute.

Assuming it is not being suggested that rebates would promote and safeguard the public health, MIEAA does not permit a plan that would rebate premiums to *past* subscribers. Instead, as earlier noted, to qualify as "community health reinvestment," an expenditure must "promote and safeguard the public health or . . . benefit current or future subscribers." D.C. Code § 31-3501(1A). The Council obviously knew the difference between current and past subscribers and it must be assumed that the exclusion of past subscribers was intentional. The statute's intent to limit benefits to *current* subscribers is confirmed by D.C. Code § 31-3506(g)(2), which provides that a reinvestment plan submitted by GHMSI "may consist entirely of expenditures for the benefit of current subscribers of the corporation." Again, there is no mention of past subscribers.

However, for several reasons, appropriate rebates to current subscribers would likely be impossible to calculate as a practical matter and their inclusion in the reinvestment plan would likely not meet the "fair and equitable" standard.

MIEAA contemplated that surplus reviews under the statute would be accomplished within the year following the year of the surplus under review. Had that been achieved, an effort to include some form of rebates to then current subscribers for their identified contribution to excess surplus might have been possible. But, as the excess surplus to be reinvested is surplus as of the end of 2011, that is likely not the case here.

[11] *Rebate*, *Random House Webster's College Dictionary* (2nd ed.1997) (emphasis added).

Many current subscribers almost certainly had nothing to do with the buildup that necessarily occurred in 2011 and prior years. Because "rebates" to such subscribers would be a windfall, they would not be fair and equitable.

Moreover, on the undisputed record before the Commissioner, the majority of GHMSI's surplus build-up did not come from premium revenue, but from investment income. Indeed, as Mark Shaw showed in his post-hearing filing, during the entire period 1998–2013 GHMSI "surplus built from underwriting gains all came from 2007 and earlier."[14] This means that any effort to isolate the extent to which current subscribers were overcharged and are now entitled to a rebate would have to identify what the payments those particular subscribers made in 2007 and prior years.

Even assuming that such current subscribers and their prior payments during the relevant years could be identified in isolation from past subscribers' payments during those years (*i.e.*, past subscribers who are not now current subscribers), there would be a further complication. With respect to group coverage, the Commissioner would need to determine how to allocate rebates between employers and employees, based on how much each contributed to premiums in 2007 and previous years, and what portion of those premiums should be deemed an overcharge subject to rebate.

Even if such calculations were attempted, there are two other factors that the Commissioner should weigh in determining whether to include the resulting rebates in the reinvestment plan.

First, a plan that allowed rebates only for those who contributed to the surplus buildup in 2007 and prior years *and* happened to still be current subscribers would likely be unfair and inequitable to past subscribers who may well have contributed more to the surplus than current subscribers. It is true that the Council itself has limited the Commissioner's ability to include those past subscribers, but that does not change the fact that rebating to some and not others would appear inequitable.

Second, whatever efforts the Commissioner expends in attempting to estimate rebates for current subscribers are unlikely to produce highly reliable estimates, and, therefore, likely to result in some subscribers receiving windfalls and some being shortchanged. Using any significant portion of the $56 million in this undertaking seems questionable. Particularly given that the overriding purpose of MIEAA was to promote and safeguard the public health,[15] the Commissioner's plan should focus on well-identified, indisputable, and pressing, community health needs; and to the extent that particular subscribers—current or past—present such needs, the plan should address them, not through rebates to all subscribers, which would be hugely overbroad and inefficient, but through the

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[14] Mark E. Shaw, *Rebuttal Report to the D.C. Department of Insurance, Securities and Banking*, United Health Actuarial Servs., Chart 19 at 34 (Nov. 7, 2014), http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/FinalShawActuarialRebuttal11-7-2014SAN.PDF.

[15] *D.C. Appleseed*, 54 A.3d at 1201.

foundations that can direct the funds to local programs that directly promote and safeguard public health. A near-impossible effort to calculate rebates for some subscribers and not others—irrespective of need—would depart from the Council's concept of a fair and equitable plan.

Finally, we note that although to date GHMSI has proposed no plan, and to our knowledge it has never proposed rebates—only future rate reductions—GHMSI may now argue that the Act gives it the right to require the Commissioner to include rebates or other benefits to subscribers in the plan, citing D.C. Code 31-3506(g)(2). This argument would be incorrect. Whether or not GHMSI submitted a plan, the Commissioner would have both the responsibility to approve a plan only if it is fair and equitable and the discretion to determine what plan best meets that standard.[16]

g. Whether there were any negative contributions to surplus made by GHMSI that should be taken into account for the plan.

As the Commissioner has defined it, satisfying the community health reinvestment standard involves two elements: (1) intentionally reducing surplus to dedicate to community health reinvestment; and (2) reducing surplus in a manner that actually results in expenditure for community health reinvestment. Thus, for any "negative contribution to surplus" to qualify as community health reinvestment, GHMSI must show both the requisite intent and the achieved result. *See In the Matter of Surplus Review and Determination for Group Hospitalization and Medical Services, Inc.*, Decision and Order on Group Hospitalization and Medical Services, Inc. Plan, Order No. 14-MIE-016 10 (D.C. Dep't of Ins., Secs., & Banking June 14, 2016) [Hereinafter June 14, 2016, Order].

While GHMSI's surplus has declined slightly since December 31, 2011, from $964 million on that date to $960 million on December 31, 2015,[17] for a number of reasons GHMSI has not and cannot show any intentional reduction of surplus for community health reinvestment during that period.

First, GHMSI has never acknowledged that it had excessive surplus at all as of December 31, 2011—even though the Acting Commissioner determined that the surplus was excessive by $268 million. Both prior to and after that determination, GHMSI has consistently maintained that it does not have excess surplus. Thus, in all of its filings with the DISB before the Acting Commissioner's ruling to the contrary—including its filings in June of 2012, 2013, and 2014—the company stated that its surplus was not excessive.[18] And even after the Acting Commissioner's ruling, the company

[16] Any reliance by GHMSI on D.C. Code § 31-3506(g)(2) would be misplaced for the further reason that it applies only to a plan submitted by GHMSI. The plan that the Commissioner is now developing is not a plan submitted by GHMSI.

[17] The most GHMSI's surplus has declined during the relevant period was from $964 million to $934 million.

[18] Letter from Chet Burrell, President & Chief Exec. Officer, CareFirst BlueCross BlueShield, to the Hon. Chester A. McPherson, Acting Comm'r, D.C. Dep't of Ins., Secs., & Banking (June 30, 2014),

has continued to maintain that it has no excess surplus—a position it took in its filings with the DISB in June 2015 and again in June 2016.[19] Indeed, it took that same position in its March 16, 2015, filing—which the Commissioner has now rejected. With this history, it seems implausible if not impossible that the company could also now maintain and demonstrate that it deliberately reduced surplus for community reinvestment during this period.

Second, when GHMSI has set out deliberately to reduce surplus it considered too high, it said so explicitly. For example, in Chet Burrell's testimony at the June 25, 2014, hearing before the Acting Commissioner, he said that GHMSI moderated or cut rates to subscribers "in 2010 going into '11" when its surplus got "too high above a target point."[20] However, GHMSI has never suggested that it has sought to reduce surplus since the end of 2011 for community health reinvestment or otherwise; rather, it has repeatedly said that its surplus should be increased.

Finally, in light of the Commissioner raising this issue, we reviewed all of GHMSI's rate filings with the DISB for products effective January 1, 2012 and later. Prior to its filings for 2017, we could find just one instance of the company intentionally seeking to reduce surplus in any of its products.[21] Neither that instance, nor the two instances in its 2017 rate filings, is explained as community benefit and distinguishable from competitive strategy.

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available at http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/CareFirstCoverLtrtoGHMSI2013SurplusReportJune302014.pdf; Grp. Hosp. & Med. Servs., Inc., *Report to the D.C. Department of Insurance, Securities and Banking Regarding GHMSI's Surplus at Year-End 2012* (July 1, 2013), *available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/CFReporttoDISBreGHMSISurplusatYrEnd2012July12013.pdf; Letter from Chet Burrell, President & Chief Executive Officer, CareFirst BlueCross BlueShield, to Comm'r William White, D.C. Dep't of Ins., Secs. & Banking (June 1, 2012), *available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/CareFirst_DISB_Report_to_Comm_White_June_1_2012.pdf.

[19] Letter from Chet Burrell, President & Chief Exec. Officer, CareFirst BlueCross BlueShield, to the Honorable Stephen Taylor, Comm'r, D.C. Dep't of Ins., Secs., & Banking (June 1, 2016), *available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/CareFirst%20Surplus%20Report%20Due%20June%201%2C%202016.pdf; Letter from Chet Burrell, President & Chief Exec. Officer, CareFirst BlueCross BlueShield, to the Hon. Chester A. McPherson, Interim Comm's, Dep't of Ins., Secs., & Banking (June 19, 2015), *available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/CBurrell%20Letter%20to%20Comm%20McPherson%20re%20GHMSI%20YE2014%20Surplus%20June19%202015.pdf.

[20] Hearing Tr. at 157:3–7.

[21] Grp. Hosp. & Med. Servs., Inc., *Rate Filing #1957* 30 (June 13, 2014), *available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/CFAP-129567873.pdf.

For all these reasons, we believe there have been no negative contributions to surplus by GHMSI that should be taken into account by the Commissioner in developing the plan.

5. In Accordance with MIEAA, the Commissioner Should Deny the Rate Increases Sought by GHMSI Beginning January 1, 2017.

MIEAA imposes on GHMSI both an obligation —the submission of a reinvestment plan— and a sanction for failure to comply with that obligation—the denial of rate increases for 12 months. The sanction is mandatory; it is not an alternative to approving a reinvestment plan. Accordingly, regardless of when a reinvestment plan is approved, the Commissioner is obligated to deny rate increases for the full 12 months prescribed by the statute and is not authorized to curtail that 12-month period.

Further, the Commissioner is proceeding properly to develop and issue a plan. As the Commissioner stated in the June 14 Order, his issuance of a plan is necessary to enforce the purposes of the Act. Rate denials are not themselves the purposes of the Act, which are to ensure that excess surplus is dedicated to community health reinvestment. The only way to achieve that statutory purpose is for the Commissioner now to develop and issue a plan. And the only way for the Commissioner to implement the statute's requirement that rates be denied to ensure GHMSI's compliance is to deny the rate increases sought by GHMSI for the 12 months beginning January 1, 2017.

a. MIEAA's Requirement to Deny Rate Increases for 12 Months is Mandatory.

MIEAA expressly commands that the Commissioner "*shall* deny for 12 months all premium rate increases for subscriber policies written in the District sought by the corporation once the Commissioner determines that GHMSI failed to submit a plan as ordered." D.C. Code § 31-3506(i) (emphasis added). MIEAA therefore creates a mandatory obligation, *see, e.g.*, *Kingdomware Techs., Inc. v. United States*, 136 U.S. 1969, 1976–77 (2016) ("shall" creates a mandatory obligation that is typically "impervious to judicial discretion")). MIEAA's use of "shall" in this provision stands in contrast with MIEAA's further provision that the Commissioner also "*may* issue such orders as are necessary to enforce the purposes" of the statute. D.C. Code § 31-3506(i) (emphasis added); *see Jama v. Immigration & Customs Enf't*, 543 U.S. 335, 346 (2005) ("The word 'may' customarily connotes discretion. That connotation is particularly apt where, as here, 'may' is used in contraposition to the word 'shall'[] . . . ." (citation omitted)). Thus, by its plain language, MIEAA provides the Commissioner no authority to issue a discretionary order that overrides his mandatory duty to deny rate increases for 12 months.[24]

[24] Similarly, the DISB's regulation allowing the Commissioner to deny rate increases "until the company complies with the order" to submit a plan, D.C. Mun Regs. tit. 26A, § 4603.3, cannot override the Commissioner's duty under the statute to deny rate increases for the full 12 months. *See Acott Ventures, LLC v. Dist. of Columbia Alcoholic Beverage Control Bd.*, 135 A.3d 80, 88 (D.C. 2016) ("[W] show deference to an agency's interpretation of its own regulations and the statutes it

The legislative history of MIEAA confirms that the provision was intended as a mandatory and independent sanction for the corporation's non-compliance. Indeed, such a provision to compel compliance directly responds to the Council's "deep uncertainty surrounding CareFirst's degree of dedication to its charitable public health mission" and desire for "a framework to ensure that CareFirst meets its public health obligation to the community." Report on Bill 17-934 at 9. To those ends, the Council explained that if the corporation failed to justify its surplus, "it may not increase its premium rates for 12 months, *and* it must implement a plan to divest the appropriate amount and allocate it toward community health reinvestment."[25] *Id.* at 12 (emphasis added). In other words, the Council intended that the Commissioner would respond to GHMSI's non-compliance by both requiring implementation of a community reinvestment plan, and denying rate increases for 12 months.

The Council's intent is reflected in the express terms of the Act, which were triggered when the Commissioner determined that GHMSI failed to submit a plan for dedicating excess surplus to community health reinvestment as ordered by the Acting Commissioner. But, although the Commissioner ordered that "[e]ffective immediately, all requests for premium rate increases for subscriber policies written by GHMSI in the District are hereby denied for 12 months from the date of this Order," he also stated that the rate increase denial would end once "the Commissioner develops and approves a plan pursuant to this Order. . . ." June 14, 2016, Order at 19.

By curtailing MIEAA's mandatory 12-month period of rate increase denials prematurely, the Order exceeds the Commissioner's authority under MIEAA, which requires both the denial of rate increases for 12 months and the issuance of a plan in order to enforce the purposes of the Act. It effectively allows GHMSI to avoid any rate denial at all, depending on the timing of reinvestment plan approval; and it signals to the company and the public that failure to submit a reinvestment plan will be met with no or a reduced sanction. In short, failure to deny rates for the full 12 months, whether or not a plan is accepted, inherently reduces the sanction expressly required by the Act, and undermines its language and purpose as enacted by the Council.

b. MIEAA Requires the 12-Month Period to Run in a Way that Sanctions the Corporation.

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administers unless the agency's interpretation is plainly wrong or inconsistent with the governing regulatory and statutory scheme.").

[25] The Committee Report refers to an earlier version of MIEAA in which the corporation's failure to justify its surplus would require both the rate denial and the submission of a reinvestment plan. Nonetheless, under MIEAA as enacted, the failure to require both outcomes after rejecting GHMSI's plan would frustrate the Council's intent. If the rate denial did not apply, GHMSI could refuse to comply and do so with impunity; or, by choosing to trigger the rate denial, GHMSI could avoid dedicating its excess surplus to community health reinvestment. Either outcome is completely out of keeping with the purpose of MIEAA and would reward noncompliance.

The Commissioner made his determination of GHMSI's failure to submit a reinvestment plan on June 14, 2016—just over thirty days after GHMSI's May 6, 2016 request for 2017 rate increases, and while approval of those rates was pending, The Commissioner also determined that "all requests for premium increases … are hereby denied for 12 months … or until the Commissioner develops and approves a plan … ." June 14, 2016, Order at 19. As we have shown, the statute does not permit the Commissioner to interrupt the running of the 12 months because he has approved a plan. Both the approval of the plan and the requirement for 12 months' denial of rate increases are mandatory. Accordingly, DC Appleseed believes the Commissioner must deny any rate increases that GHMSI has proposed and that otherwise would become effective for calendar year 2017, thereby giving effect to the statutory requirement. Denying all rate increases during calendar 2017 sanctions GHMSI with the full 12-month bar on rate increases that MIEAA and the D.C. Council intended.[26]

6. Conclusion

The Commissioner should order GHMSI to transfer the $56 million excess surplus to a trust that is approved by the Commissioner, and that is managed by a group of foundations pursuant to guidelines approved by the Commissioner. The Commissioner should also deny the pending rate increases that GHMSI has sought for calendar year 2017.

[26] If the Commissioner's order finding that GHMSI's March 2015 submission did not comply with MIEAA had been issued prior to the approval of GHSMI's proposed rates for calendar 2016, GHMSI would not have been able to implement the substantial rate increases that went into effect in January 2016.